# Hospital Fraud and Abuse

## *Why look at hospital services?*

- Patients are often unaware of all the services they are receiving.
- Medicare payment rules for hospital services are complex.
- There are not enough Medicare auditors to conduct extensive, detailed audits.
- Generally, no Explanation of Medicaid Benefit forms are sent to Medicaid recipients so, unlike with Medicare, it is hard for recipients or their families to check whether Medicaid has been billed correctly for hospital services provided.

## *Fraud schemes:*

- **Billing for Out-Patient Services while the beneficiary is an Inpatient.** The discharge date is misrepresented in order to obtain both inpatient and outpatient reimbursement.

  **For example**, it is to the benefit of the acute hospital to show the beneficiary as discharged from the facility when, in fact, the beneficiary really has not been. This allows the hospital to bill Medicare for the Diagnosis Related Group (DRG) Payment, which is billed at the end of a stay *(DRG payment is based on the diagnosis rather than the length of stay)*. The hospital can then begin billing Medicare for outpatient services, although the beneficiary may have never left the hospital.

  **For example**, one drug and alcohol rehabilitation facility discharged its inpatients on paper, but not in reality. The hospital received the DRG reimbursement for the inpatient stay and then also billed for outpatient services. Since the patients had not yet left the hospital, the facility should have only billed for the DRG payment.

- **Billing for more services than were provided. For example**, billing for multiple x-ray views when only one view was taken.

- **UPCODING the diagnosis on the Medicare claim form to receive a higher payment.** Some conditions or diagnoses (Diagnosis Related Groups or DRGs) yield higher payments than others.

- **Billing for patients under observation.** Some patients may be held in observation status for 3 or 4 days, rather than admitting them as hospital inpatients. Hospital observation services are reimbursed as a percentage of charges (through Medicare Part B). so the Medicare payment is usually higher than what the facility would have received through the inpatient DRG reimbursement.

- **Billing for unnecessary procedures:**

  **For example**, in August 2003 Tenet Healthcare, the second-largest for-profit hospital chain in the nation, agreed to pay $54 million to settle allegations that two physicians at Tenet-owned Redding Medical Center in California participated in a "scheme to cause patients to undergo unnecessary invasive coronary procedures," such as artery bypass and heart valve replacement surgeries in order to defraud Medicare. This is the largest settlement recovered from a hospital in a case related to alleged unnecessary surgeries or other medical services. [1]

- **KICKBACKS** – an arrangement between two parties which involves an offer to pay for Medicare or Medicaid business. Kickbacks generate extra business for the participants and unneeded services for the patients. They also drain scarce tax dollars. Health care providers engaging in kickback activities are subject to criminal prosecution and exclusion from the Medicare and Medicaid programs.

  **For example**, in September 2003 the U.S. Department of Justice (DOJ) concluded "the most comprehensive health care fraud investigation ever undertaken" by the agency with $1.7 billion recovered from HCA, Inc. for submitting false claims to Medicare and Medicaid.[2] This is by far the largest recovery ever reached by the United States in a health care fraud investigation.

[1] Los Angeles Times (8/7/03); Kaiser Daily Health Policy Report (11/1/02).
[2] *Historic settlement nets United States $1.7 billion,* Andrews Online (9/5/03).

The company has agreed to pay the United States $631 million in civil penalties and damages to bring an end to the government's case. The government previously collected $840 million from HCA after two of the companies' subsidiaries pleaded guilty to substantial criminal conduct in December 2000. In addition to the most recent settlement, HCA will pay $250 million to resolve overpayment claims arising from its cost reporting practices.

The settlement will resolve fraud allegations against HCA and its hospitals in nine different False Claims Act whistleblower suits.[3] As part of the deal, HCA will pay $356 million to end claims that it submitted false statements to Medicare, Medicaid and TRICARE, the military's health care program. Another $225.5 million will go toward resolving suits alleging that HCA hospitals engaged in paying out kickbacks and other illegal remuneration to physicians in exchange for patient referrals.

**"Medicare dollars paid to provide ever more expensive health care services to the country's taxpayers should never be fraudulently diverted,"** said Acting Principal Deputy Inspector General Dara Corrigan. **"Health care providers and professionals hold a public trust, and when that trust is violated by fraud and abuse of program funds, and by the payment of kickbacks to the physicians on whom patients and the programs rely for uncompromised medical judgment, health care for all Americans suffers,"** said Assistant Attorney General Robert D. McCallum Jr. of the Justice Department's Civil Division.

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[3] A law known as the False Claims Act allows whistleblowers to bring "qui tam" lawsuits — basically civil fraud lawsuits filed on behalf of the government — against companies and individuals that are cheating the government. Liable defendants in qui tam cases must pay the government for its losses and pay penalties for fraud. A whistleblower who brings a successful qui tam case under the False Claims Act is entitled to a reward, which is based on the amount of money the government recovers. Some of the types of fraud against the government that can be the basis of a qui tam lawsuit include Medicare fraud, Medicaid fraud, defense contractor fraud, customs fraud, bid-rigging on government projects, environmental fraud and research fraud. “Qui tam” is short for the Latin phrase – “qui tam pro domino rege quam pro se ipso in hac parte sequitur” – which translates as “he who brings an action for the king as well as for himself.”

- **Double billing:** A hospital bills both Medicare or Medicaid and the recipient (or private insurance) for the same health care service or goods, or two providers bill for the same service.

  **For example**, A Miami hospital will pay a whopping $16.8 million to settle a whistleblower suit filed by a former Florida Medicaid employee charging that it double-billed Medicaid. Both Jackson Memorial Hospital and its outpatient clinics billed Medicaid under their respective provider numbers for the same covered service. The former employee (whistleblower) who filed the case will collect about $1.4 million.[4]

## *Know your hospital rights:*

When you go into a Medicare-participating hospital, make sure you receive and read **"An Important Message from Medicare,"** which is an explanation of your Medicare rights. The message (available in English or Spanish) explains that every hospital patient on Medicare has these same basic rights:

- The right to get all the hospital care that you need and any follow-up care after you leave the hospital,

- The right to be sent home from the hospital only when it is best for your medical needs,

- The right to get a written plan for your continued care at home when you leave the hospital,

- The right to be told about decisions that affect whether or not Medicare will pay your bill, and

- The right to receive a written **"Notice of Non-Coverage"** if Medicare won't pay.

[4] *Official Blows the Whistle On Provider,* Hospital Compliance Wire, MIAMI (7/22/03).

If you disagree with a hospital's decision to send you home, after discussing your discharge with your doctor and reviewing the Notice of Non-Coverage, call Arkansas Foundation for Medical Care (AFMC) at 888-354-9100 to request an immediate review of your case. You may be able to stay in the hospital at no charge while they review your case. The hospital cannot force you to leave before AFMC makes a decision.

## *Things to look for:*

- Review your Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) to ensure that the services billed match the services that were provided. (NOTE, however, that for inpatient services, the itemized charges usually do not have an impact on the Medicare reimbursement).

- Beneficiaries should check to make sure that the admitting and discharge dates are accurate.

It is in your best interest and that of all citizens to report suspected fraud. Health care fraud, whether against Medicare, Medicaid or private insurers, increases everyone's health care costs, much the same as shoplifting increases the costs of the food we eat and the clothes we wear. If we are to maintain and sustain our current health care system, we must work together to reduce costs.

**To Report Suspected Medicare or Medicaid Fraud**

Call Toll-free 1-866-726-2916

Or Write to Address Below